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DESCRIPTION OF NURSING SHIFT HANDOVER IMPLEMENTATION IN ONE OF PROVINCIAL PUBLIC HOSPITALS IN DKI JAKARTA PROVINCE

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ABSTRACT

The nursing handover has important consequences in the quality of nursing care to ensure continuity of care and patient safety. The purpose of this study was to describe the phenomenon related to nursing shift handover process in one of the provincial public hospitals in DKI Jakarta province. The method was descriptive study. Data collection was done by interview, documentation study, questionnaires and observation of the handover. This study began with initial assessment in 8 inpatient wards using planning, organizing, staffing, actuating, and controlling (POSAC) approach, problem identification by using fishbone analysis, problem priority and gab analysis by using literature review. The result obtained from the planning function was no available guide and standard operating procedure (SOP) on nursing shift handover yet, from the organizing function was wide span of control of the head nurse, from the staffing function was lack of understanding and commitment of nurses in delivering effective communication during the handover, from the actuating function was no periodic supervision of nursing shift handover process, and from the controlling function was constraint related to shift handover procedure in which it was different per shift. The main problem was from the planning function in which there was no available guide, and SOP on nursing shift handover yet. Nurses require an effective communication technique in the standardized handover to communicate the patient's information adequately. The recommendation of the hospital is to be able to develop a guide and SOP for nursing shift handover to make the process of nursing shift handover more effective, efficient and structured.

KEYWORDS: Effective Communication, Handover, Nurse & Patient Safety

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Original Article

INTRODUCTION

Nursing handover is an urgent activity undertaken by the nurse as a health professional to ensure continuity and patient safety. Nursing handover is an important activity to ensure continuity of care for inpatients as the nurses are the spearhead of health personnel to ensure the continuity of patient care in 24 hours a day, seven days a week, not only because of their presence both day and night but also because they are seen as communication partners for all professional health services (Smeulers, Lucas, & Vermeulen, 2014). The purpose of handover is to give the patient's information from one shift to another to ensure safe and effective patient care (Scovell, 2010). Good handover means reducing irregularities in terms of continuity of care, errors, and dangers for patients (Jorm, White, & Kaneen, 2009). Nursing handover becomes an important moment for nurses to give the patient's information between nursing shifts and to ensure the continuity of safe and effective care.

Nursing handover is a major method of continuous patient care in the hospital. The handover is a key method to enable continuous patient care in the hospital (Randell, Wilson, Woodward, & Galliers, 2010). The handover will be effective if the continuity of patient care takes place properly and there are minimal errors and dangers inflicted on the patient (Jorm et al., 2009). The nursing handover is an important method for determining the continuity of patient care.

The continuity of patient care depends on the information provided by the nurse when the nursing shift changes. Adequate information in the handover is vital to ensure continuity of patient care and safety (Smeulers et al., 2014). The information given in the handover must be complete, accurate, and consistent to prevent harm to the patient's safety (Vines, Dupler, Son, & Guido, 2014). Information about the patient's care, treatment, service, and conditions should be accurately delivered during patient handover (Ardoin & Broussard, 2011). The handover between shifts in nursing plays an important role in improving patient safety if patient information is communicated precisely, accurately and effectively.

Effective communication in the handover plays an important role in the continuity of patient care and safety. Effective communication during the handover is important in ensuring the safe and qualified patient care (Abraham et al., 2016). The shortcomings and failures of the communication process during the handover are the root causes of problems from patient safety (Groene, Orrego, Suñol, Barach, & Groene, 2012; Kerr, Lu, & Mckinlay, 2013). Communication errors during the handover can lead to unexpected events and not optimal patient care (Welsh, Flanagan, & Ebright, 2010).

Johnson, Jefferies, & Nicholls, (2012) also mention that the gap occurring in communication during handover has been associated with delays in diagnosis, medication errors, impairment in a continuity of care and bad things that lead to the length of stay. Effective communication becomes important in nursing shift handover activities to improve patient safety.

Communication errors during handover are a major factor in causing patient safety incidents. Communication errors were reported as a major contributory factor of more than 70% of all sentinel events (Vinu & Kane, 2016), and communication errors during patient handover accounted for 12% of patient safety incidents (Pronovost et al., 2006). 489 sentinel events were caused by communication errors in 2014 (Joint Commission, 2015). Communication errors during handover lead to various patient safety incidents.

The number of patient safety incidents due to ineffective communication during handover encourages the need for a standardized technique or method in order to make the handover process more structured. Patient safety incidents due to ineffective communication, encourage the need to develop a structure or method for handover implementation as part of the national patient safety objective, the use of standardized methods supported by evidence from literature indicating that consistency in reporting practices and use of structured tools for communication helps improve the quality of handover (Ayala, 2017). The nurses require a structured technique that can be used in the handover process. The structured techniques that can be used in the handover process vary, all of which work together effectively and in a relevant way that can help the nurse to improve effective communication in the handover (Ballantyne, 2017).

Implementation of effective communication techniques during the handover has not been optimally applied in several hospitals in Indonesia; one of them is a provincial hospital in the DKI Jakarta province as non-education type B hospital which is committed to continuously improve services. In 2012, quality improvement program and patient safety in this hospital set hospital indicator in accordance with the standard Quality and Patient Safety Improvement (QPSI) from 2012 Version of KARS. However, based on the interview with the head of nursing, the head of quality unit service and the

head of a human resource unit service and 5 heads of the provincial public hospital ward it was found that the implementation of effective communication technique during the nursing shift handover was not optimal.

The result of the preliminary study showed that the head of the division and the head nurse stated that there was no specific rule related to the implementation of a standardized handover so that the handover implementation was not uniform throughout the inpatient wards. The head of nursing and the head of the ward also stated the lack of understanding and commitment of nurses to the implementation of effective communication during nursing shift handover, thus it made the implementation of the handover less effective. Based on the background above, the writers are interested to identify the description of the implementation of handover in one of the provincial public hospitals in DKI Jakarta province.

METHOD

The method used in this study is the descriptive method in which the writers describe the phenomenon related to the implementation of a nursing shift handover systematically in one of the provincial public hospital in DKI Jakarta province through the management function approach, Planning-Organizing-Staffing-Actuating-Controlling (POSAC). This study was started by preliminary assessment, identification of problems by using a fish bone analysis approach, and gab analysis by using the literature review.

Interviews were conducted to the head of nursing and 5 head nurse, while the questionnaires were distributed to the nurses in the wards. Initial data collection was taken from 8 inpatient wards. The instrument of the interviews in this study used an interview guideline based on planning, organizing, staffing, actuating, and controlling (POSAC) approach.

The questionnaires distributed to the nurses have also used the POSAC approach. These questionnaires consisted of two types. The first questionnaire was about the nurse's perception of the head of the ward related to the handover implementation and the second questionnaire was related to the nursing shift implementation by the nurses. As an ethical consideration of this study, all instruments used were consulted to the supervisor and went through the permitting process to the head of nursing division in the hospital prior to the dissemination. The respondents' data in each instrument used the initial name and were not presented in the presentation of result analysis.

Problem identification was analyzed by using fish bone analysis approach. Problems were broken down into a number of related categories; these categories were based on the management functions which were planning, organizing, staffing, actuating and controlling (POSAC).

RESULTS

The description of the phenomenon related to the implementation of handover among nursing shifts in RSUD is obtained by first conducting the initial assessment through management function approach that is planning, organizing, staffing, actuating, and controlling (POSAC). In the planning function, it was found that there was no specific policy regarding the implementation of nursing shift handover. This was obtained based on the results of documentation studies and interviews with the head of nursing. The results of interviews with the head nurse from 8 inpatient wards also showed the lack of guidance and SOP of patient handover between nursing shifts. This resulted in the unstructured implementation of the nursing shift handover.

Related to the organizing function, the result of interviews with the head nurse and observation showed that 3 head nurse experienced a wide range of controls (1 head of the room controlling 2 rooms at once). This became an obstacle

during the handover, especially in morning shift change.

Regarding the staffing function, it was obtained that based on the results of an interviews with the head of nursing the nurses had less commitment and less understanding in the application of effective communication techniques during handover causing the implementation of handover less optimal.

The results of the observation of the handover done by the writers also showed that not all nurses from the next shift were present during the handover, in which all nurses from the next shift or nurses who will serve next should be present during the handover to know all information related to the condition of patient who will be treated. The nurse who gave the information also did not mention her name first when she started the handover. The name of the informant should be mentioned so that the identity of the informant is known, especially during the bedside handover to make the patient know the nurse who treats him. The result of the analysis on the actuating function was that there was no regular supervision on the handover from either the head of the ward or the nursing division. However, the head of the ward always gave motivation to the nurses in every outpatient ward to always carry out the patient handover according to the standard. This is in line with the result of the questionnaire which showed 95.24% of the nurses stated that the head of the ward gave motivation to the nurses in each of the outpatient nursing wards to always carry out the patient handover according to the standard.

Related to the control function, the result of interview with the head of the ward found that the head of the ward never conducted a survey on the nurse satisfaction over the implementation of the patient handover. The head of the ward also stated that the constraint related to the handover implementation was the difference in the information delivery method during the handover among the wards, even every shift change. This was in line with the result of questionnaires distributed to the nurses. Based on the result of the questionnaires, it was found that 64.29% of nurses stated that the constraint faced during the handover was when the information provided by the nurses of each shift varies in sequence. This proved that there was no specific rule in the implementation of patient handover between nursing shifts and there was also no structured technique applied in the handover process. The above results were part of the problem analysis with the fishbone approach. The root cause of the problem was identified by the author in the form of a fishbone diagram which can be seen in Figure 1 as follows:

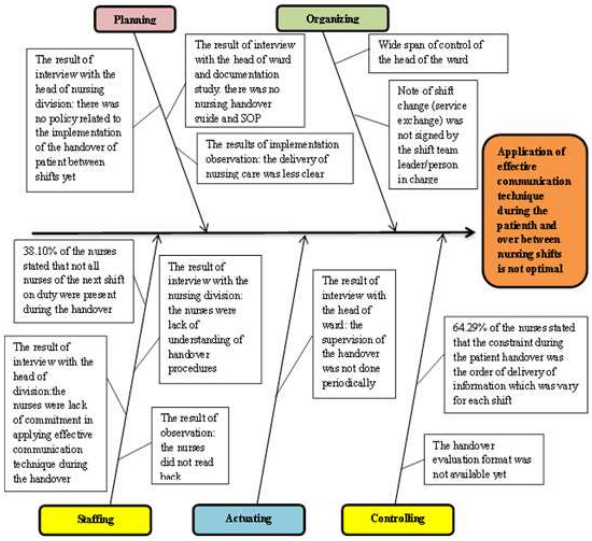

Figure 1: Fishbone Diagram of Root Problem Determination

Figure 1 shows that the implementation of an effective communication technique was not optimal during the nursing shift handover. Analysis of root problem using fishbone indicated some causes of problem seen from the management function which was related to the planning function in which there were no policy, guide, and SOP of the handover yet, and the delivery of information about nursing care was also unclear.

Related to the problem root organization function, it was found that the span of control of the head of a ward was wide. Related to the staffing function, it was found that the roots of the problem were not all nurses from the next shift were present during the handover and there was lack of understanding and commitment of nurses about effective communication during the handover. Related to the actuating function, it was found that there was no periodic supervision of the handover implementation and related to the control function, the root of the problem was that constrain during the handover of the patient was the order of information delivery during the handover varies for each shift.

Having obtained the roots of the problem with fishbone analysis the priority of the problem was set. Determination of problem priority was done by using magnitude (M), severity (S), manageable (Mn), nursing concern (Nc), and affordable (Af). The result of the assessment showed that the priority of the problems was on the planning function in which there was no guide and SOP related to the nursing shift handover.

After mutual agreement related to problem priority determination was obtained, the writers and the hospital parties determined a plan of action (POA) as the action plan of the problem-solving implementation.

DISCUSSIONS

The nursing handover is an important activity routinely performed by nurses in daily nursing practice. The nursing handover is an important and routine part of daily nursing practice where information related to patient care is delivered from one nurse to another during the shift handover (O'Connell, Macdonald, & Kelly, 2008). The nursing handover has important consequences in the quality of nursing care provided by the nurses routinely for the continuity of patient care (Meibner et al., 2007). The nursing shift handover is a routine and important nursing activity to ensure continuity of care in the patient.

The continuity of patient care depends on the information provided by the nurse during the nursing shift change. The information reported during the handover must be complete, accurate and consistent in order to prevent harm to the patient's safety (Vines et al., 2014). Information on patient care, treatment, services, and patient conditions should be accurately delivered during patient handover (Ardoin & Broussard, 2011). The nursing shift handover plays an important role in improving patient safety if patient information is communicated precisely, accurately and effectively.

Effective communication is an important component in the implementation of nursing shift handover to improve patient safety. Effective communication is essential in the handover procedure in which it is in line with the second goal of the international patient safety program (Smith, Pope, Goodwin, & Mort, 2008). This is also stated in Permenkes No.11 of 2017 on patient safety and accreditation standard of the hospital in 2017 which is SKP 2.2. Effective communication becomes an important point in the nursing shift handover because it provides accurate, up-to-date information about treatment, service, patient condition, and change to patient (Care, Adams & Osborne-mckenzie, 2012) to ensure safe, qualified, and effective treatment to the patient (King, Cynthia & Gerard, 2016). Effective communication becomes important in handover activities between nursing shifts to improve patient safety.

The nursing problem that arose after the writers conducted an assessment at one of the provincial public hospitals in DKI Jakarta province was that the application of effective communication technique during the nursing shift handover was not optimal. The assessment was conducted by the writers by using the nursing management function approach related to the implementation of the handover between nursing shifts.

The result of the assessment of the planning function was the unavailability of guide and SOP about the handover between the nursing shifts so that the handover implementation became less structured and optimal. Guide and SPO is very important as a manual in conducting activities so that the implementation of the handover becomes effective, efficient, safe to improve the quality of service. The purpose of developing this SOP is to ensure that various routine work processes are carried out efficiently, effectively, consistently / uniformly and safely, in order to improve the quality of service through compliance with applicable standards (KARS, 2012). The National Clinical Effectiveness Committee (2015) explains that the purpose of providing a handover guide is to optimize the clinical handover process and to improve patient safety by delivering the essential elements so that the handover implementation can be completed on time, accurately, completely, unambiguously and focused. Handover guide is important to make the handover process more effective, efficient, accurate, consistent/uniform and improve the quality of service.

The result of the assessment related to the organizing function was the wide span of control from the head nurse (there was the head of the ward who was responsible for two wards with the different character) making it difficult to control the implementation of the handover at once. Physically it is unlikely that a leader can consistently improve positive leadership with an enormous amount of staffs, while at the same time ensure effective and efficient implementation of activities on a large unit each day (Doran et al., 2004). A span of control that is too wide made the head of the ward difficult in ensuring effective and efficient handover activities.

The result of the assessment of the staffing function based on the interview with the head of the nursing was that the nurses were not really understanding and lack of commitment in applying an effective communication technique during the patient handover so that the handover implementation was also less structured. The interview with the head nurse also showed that the nurses knew about the communication technique such as SBAR but they did not apply it in the handover implementation. Understanding and commitment of nurses can affect the ability to perform an action. This is in line with the statements of Yulia, Hamid, & Mustikasari (2012) in which people's cognitive abilities influence their ability to perform actions that do not cause a patient's safety risk. Another study found that effective and normative commitment is significantly correlated with the performance of nurses (Muliyadi, Hamid, & Mustikasari, 2010). Understanding and commitment of nurses affect the performance of nurses in the handover implementation.

The result of the other assessment related to the staffing function was that not all nurses of the next shift were present during the handover. All nurses of the next shift should be present during the handover because the nurses from the next shift will continue the patient's treatment. Nursing handover must be attended by all nurses of the next shift and a nursing coordinator/person in charge of the shift from the previous shift (Chaboyer, McMurray, & Wallis, 2010). In special case such as bedside handover, the ones who participate are the team leader (person in charge of shift) of the previous shift and three team members of the next shift (Chaboyer et al., 2010). The nurses of the next shift (the nurse who will serve next) must follow the patient handover because the next shift will continue the treatment to the patient in the ward, so they should know all information about the patient.

The result of the actuating function showed that there was no regular supervision of the handover of either the head of the ward or from the nursing division. Supervision or direction is important to improve staffs' motivation in implementing an activity so that their performances become better. Supervision activities can increase employees' motivation, enthusiasm, and confidence, causing employees to be more driven and improving their performance so they tend to do their best (Zhou, Ma, & Dong, 2017). Supervision is important to improve motivation, spirit, and performance of nurses in performing activities including handover activities.

The result of the assessment from the control function seen from the constraints faced during the handover process showed that 64.29% of the nurses stated that the constraint faced during the handover was when the information delivered during the handover of each shift varies in order and each ward also differs in delivery. This was due to no guide and SOP set for the nursing shift handover implementation so that the handover implementation was not uniform. The most common difficulty experienced by the nurses in carrying out the handover optimally was the lack of handover guides and how to determine what information should be reported (Ayala, 2017). The absence of the structured standard and the diversity of practice backgrounds make the handover process inconsistent (Vinu & Kane, 2016). The uniformity of the handover implementation assists the nurses in receiving clear information regarding the patient handover both between shifts and between wards/units.

After the identification of needs and problems of nursing care related to the implementation of the handover was obtained, the writers set the priority of needs and problems of nursing management with the hospital. Priority of planning issues is an essential management function that is essential in generating satisfactory decisions, problem-solving and planned effective changes (Swansburg, 2000). Planning is a management function of problem priority determination, outcome and method of achieving outcomes, planning in determining long-term and short-term goals as well as related to actions to be taken to achieve those goals (Huber, 2010). Planning is a basic function of management and the determination of priority issues that determine long-term and short-term goals and related to the actions that must be done to achieve those goals.

The main priority problem in this study was in the planning function in which there was no guide and SOP related to the nursing shift handover. Guide and SPO are essential so that all work processes are more targeted and consistent. The purpose of the guide and SPO development is to make the work processes more focused and routine to be done consistently/uniformly (KARS, 2012). The absence of a structured standard makes the handover process inconsistent (Vinu & Kane, 2016). Guide and SOP are essential so that the activities can be more targeted and consistent.

Development of handover guide and SOP is essential so that the handover process becomes more effective, accurate, and it can reduce repetition of the information delivered so that the handover process becomes more efficient. The National Clinical Effectiveness Committee (2015) explains that the purpose of providing a handover guide is to optimize the clinical handover process and to improve patient safety by delivering essential elements so that the handover implementation can be completed on time, accurately, completely, unambiguously and focused. Dunn (2017) also states that a standard handover implementation is required to ensure the smooth transfer of information, care and management of the security of service users (patients) in the inpatient ward. Handover guide and SOP are essential so that the handover process is more effective, efficient, consistent, and ensures smooth delivery of information and safety of patient care.

CONCLUSIONS

The patient handover between nursing shifts is an important moment that routinely occurs in daily nursing practice to communicate relevant and important information regarding the patient's condition during shift change. Effective communication becomes an important point in the nursing shift handover as it provides accurate, up-to-date information about care, service, patient condition, and recent changes in the patient so it can ensure safe quality, and effective care is provided to a patient.

The nurse requires an effective communication technique in standardized handover so that patient information can be adequately communicated. Handover guide and SPO using an effective communication technique are important as a standard to optimize the clinical handover process by delivering the essential elements so that the handover implementation process becomes more effective, efficient, accurate, consistent/uniform, and improves patient safety.

The recommendation given to hospital is to develop handover guide and SOP between nursing shifts so that the process of nursing shift handover implementation becomes more effective, efficient and structured.

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